

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

579

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00575

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Charles</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Olson Springs</i>				c. LENGTH OF STAY IN 1b <i>4 yrs</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Helen Daisy Ashton</i>				4. DATE OF DEATH Month <i>January</i> Day <i>5</i> Year <i>1958</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 14, 1881</i>	9. AGE (In years last birthday) <i>76</i> yrs.	IF UNDER 1 YEAR Months <i></i> Days <i></i> Hours <i></i> Min. <i></i>	IF UNDER 24 HRS. Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Horse raising</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Pisgah</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>William Queen</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth Victoria Gidy</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i></i>		17. INFORMANT <i>Abel E. Bowison</i>		Address <i>Pisgah, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Hypertensive Heart Disease</i> DUE TO (c) <i></i> (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <i>Immed.</i> <i>4 yrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Pernicious Anemia</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Frank A. Susan</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <i>Frank A. Susan M.D.</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<i>1/5/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>Jan. 9, 1958</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St. Charles</i>		22d. LOCATION (City, town, or county) (State) <i>Glymont Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Huntt Farm Home, Waldorf, Md.</i>				ADDRESS		24a. REC'D BY REGISTRAR <i>JAN 10 58</i>	
						24b. REGISTRAR'S SIGNATURE <i>W. E. Bowison</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the office of the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the medical examiner prior to burial, cremation, or removal.

JAN 10 1959

RECEIVED

580
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Saplata</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Ironsides md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Phy Mem Hopt</i>		d. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) <i>JAMES WATSON BROCK</i>		4. DATE OF DEATH Month <i>1</i> Day <i>11</i> Year <i>1958</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <i>37</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Semiretired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Thurman</i>	
11. BIRTHPLACE (State or foreign country) <i>West Virginia</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13. FATHER'S NAME <i>Dave Brock</i>		14. MOTHER'S MAIDEN NAME <i>Vester Eagers</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Gladys Brock</i>		Address <i>Ironsides md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>824X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <i>AUTO ACCIDENT</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1-11-58</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Driver of CAR WHICH SKIDDED & THREW HIM OUT</i>	
20c. TIME OF INJURY Hour <i>1</i> a.m. <i>11</i> p.m. <i>1958</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Away</i>		20f. (City or town) <i>IRONSIDES CHAS</i> (County) <i>md.</i> (State)	
21. I certify that I attended the deceased from <i>MD EXAM CASE</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>1-11-58</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>L A PHATA MD</i> DATE SIGNED <i>1-11-58</i>	
ACTUAL SIGNATURE <i>E. J. EDELEN</i>		M.D. <i>E. J. EDELEN</i>	
PHYSICIAN'S NAME (Type) <i>E. J. EDELEN</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1-14-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Roberts Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Morton wa</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Archart Inc</i>		24a. REC'D BY REGISTRAR <i>Saplata md</i> DATE <i>JAN 14 '58</i>	
		24b. REGISTRAR'S SIGNATURE <i>Archart Inc</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 14 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
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the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G225 1-31-58 et

581

CERTIFICATE OF DEATH

Reg. Dist. No.

00577

1. PLACE OF DEATH a. COUNTY MARYLAND CHARLES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY CHARLES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WALDORF				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X WALDORF			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last LESTER EDWARD CLARK				4. DATE OF DEATH Month Day Year JAN 21 19 58			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG 21, 1883	
9. AGE (In years last birthday) 74 1/2 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER				10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.	
12. CITIZEN OF WHAT COUNTRY? USA.							
13. FATHER'S NAME EDWARD CLARK				14. MOTHER'S MAIDEN NAME EULALIE BROWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 218 09 6767		17. INFORMANT Address MRS Lottie A. CLARK WALDORF, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO myocardi infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 420.1 DUE TO coronary atherosclerosis (c) 420.1 DUE TO senile atherosclerosis						INTERVAL BETWEEN ONSET AND DEATH 1 Day yes yes	
						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1-16, 19 58, to 1-21, 19 58, that I last saw the deceased alive on 1-24-58, 19, and that death occurred at 1:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Reuben Doherty</u> M.D. <u>Reuben Doherty, Md.</u> PHYSICIAN'S NAME (Type) <u>Reuben Doherty</u> <u>Reuben Doherty, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-24-58		22c. NAME OF CEMETERY OR CREMATORY ST Peter's Ctm.		22d. LOCATION (City, town, or county) (State) WALDORF, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE HUNT FUNERAL Home, WALDORF, Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE JAN 27 1958	
				24b. REGISTRAR'S SIGNATURE A. L. Smith			

CERTIFICATE OF DEATH

1953

NAME OF DECEASED <i>George Washington</i>		DATE OF BIRTH <i>1-1-18</i>
RESIDENCE <i>1000 ...</i>		DATE OF DEATH <i>1-27-53</i>
PLACE OF DEATH <i>Home</i>		CAUSE OF DEATH <i>Myocardial Infarction</i>
MANNER OF DEATH <i>Natural</i>		DATE OF INTERMENT <i>1-28-53</i>
PLACE OF INTERMENT <i>St. ...</i>		NAME OF MINISTER <i>...</i>
NAME OF PHYSICIAN <i>...</i>		NAME OF CORONER <i>...</i>
NAME OF FUNERAL HOME <i>...</i>		NAME OF BURIAL PLACE <i>...</i>

George Washington
Myocardial Infarction
1-1-18
1-27-53

1000 ...
...
...

BUREAU V. S.

JAN 27 1953

RECEIVED

582

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CHARLES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LA PLATA</u>				c. LENGTH OF STAY IN 1b <u>4 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PHYSICIANS' MEMORIAL HOSPITAL</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DENTSVILLE (RURAL)</u>			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) MIDDLE <u>MARY</u> FIRST <u>ELIZABETH</u> Last <u>COOKSEY</u>				4. DATE OF DEATH Month <u>JANUARY</u> Day <u>19</u> Year <u>1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE-UK</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPTEMBER 12, 1875</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>WILLIAM H. CRESMOND</u>				14. MOTHER'S MAIDEN NAME <u>MARY ANNA ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>WILLIAM ELMER COOKSEY; DENTSVILLE, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO SCLEROTIC HEART DISEASE (CORONARY 420.0</u> DUE TO <u>INSUFFICIENCY)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO SCLEROSIS WITH HYPERTENSION</u> DUE TO (c) <u>DIABETES MELLITUS (MILD)</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 DAYS</u> <u>15 YEARS</u> <u>4 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JANUARY 1950</u> , to <u>JANUARY 19, 1958</u> , that I last saw the deceased alive on <u>JANUARY 19, 1958</u> , and that death occurred at <u>7:10 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>DENTSVILLE, MD.</u> DATE SIGNED <u>1/20/58</u>							
ACTUAL SIGNATURE <u>John W. Griffin</u> M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-22-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST MARY'S CEM</u>		22d. LOCATION (City, town, or county) (State) <u>NEWPORT, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Huntt Funeral Home</u>				ADDRESS <u>WALDORE, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 23 58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. L. Smith</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 23 1950

RECEIVED

583

CERTIFICATE OF DEATH

Reg. Dist. No.

00529

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata,				c. LENGTH OF STAY IN TB 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital				d. STREET ADDRESS ---			
3. NAME OF DECEASED (Type or print) First Owen Middle Grimes Last Grimes				4. DATE OF DEATH Month January Day 18 Year 1958			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 23, 1891	
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min. 66		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tobacco Farmer				10b. KIND OF BUSINESS OR INDUSTRY Own Farm			
13. FATHER'S NAME Henry W. Grimes				14. MOTHER'S MAIDEN NAME Sarah M. Hyde			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service) --				17. INFORMANT Pearl Grimes - Rt. #1, Box 60, Brandywine, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vas. Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) ??						INTERVAL BETWEEN ONSET AND DEATH 1-16-58	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ??							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) La Plata				20g. (County) MD.		20h. (State) MD.	
21. I certify that I attended the deceased from 1-16-58 to 1-18-58 , that I last saw the deceased alive on 1-18-58 , and that death occurred at 10 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE E. J. Foreman				DATE SIGNED 1-19-58			
PHYSICIAN'S NAME (Type) E. J. Foreman				ADDRESS (Street, city or town, state) La Plata, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/22/58		22c. NAME OF CEMETERY OR CREMATORY Cedarville Cemetery		22d. LOCATION (City, town, or county) (State) Cedarville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home				24a. REC'D BY REGISTRAR JAN 27 '58			
ADDRESS Upper Marlboro, Md.				24b. REGISTRAR'S SIGNATURE Alfred Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, date of death, cause of death, and place of death. The form is partially filled out with handwritten and printed text.

RECEIVED
JAN 27 1939
BUREAU V. S.

584

CERTIFICATE OF DEATH

00580

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Victoria				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) Frank First Hemsley Middle Hemsley Last				4. DATE OF DEATH Month 1 Day 7 Year 1958			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-7-1878	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Hemsley				14. MOTHER'S MAIDEN NAME Mary ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Eddie Hemsley Mt Victoria, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1955 1955
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-28-'55 , 19 55 , to 1-7 , 19 58 , that I last saw the deceased alive on Nov. 9 , 19 57 , and that death occurred at 3 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) La Plata, Md. DATE SIGNED 1-10-'58 ACTUAL SIGNATURE E. J. Edelen M.D. PHYSICIAN'S NAME (Type) E. J. Edelen, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-11-58		22c. NAME OF CEMETERY OR CREMATORY Holy Ghost Cem.		22d. LOCATION (City, town, or county) (State) Issue, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Huntt Funeral Home				ADDRESS Waldorf, Md.		24a. RECEIVED BY REGISTRAR DATE JAN 13 1958	
				24b. REGISTRAR'S SIGNATURE W. H. H.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

and one for

DATE OF DEATH

PLACE

DATE

PLACE

DATE

DATE OF DEATH

PLACE

CAUSE OF DEATH

PLACE

DATE

DATE

DATE

DATE

DATE

DATE

DATE

DATE

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DATE

DATE

DATE

BUREAU V. S.
JAN 13 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

585

Item 9 Film G225 2-7-58 et
CERTIFICATE OF DEATH

Reg. Dist. No.

00581

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Plains</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Plains</u>	
3. NAME OF DECEASED (Type or print) <u>EDWARD</u> First <u>IAYTON</u> Middle <u>JOHNSON</u> Last		4. DATE OF DEATH Month <u>Jan</u> Day <u>28</u> Year <u>19 58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 29, 1888</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Martha Humphrey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Charlotte Johnson, White Plains, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-Sclerotic Heart Disease</u> <u>443 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterial Hypertension</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Indefinite</u> <u>Indefinite</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-10-54</u> , 19 <u> </u> , to <u>1-28-58</u> , 19 <u> </u> , that I last saw the deceased alive on <u>1-28-58</u> , 19 <u> </u> , and that death occurred at <u>4:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>17-Potomac Ave Indian Head Md.</u> DATE SIGNED <u>1-28-58</u> ACTUAL SIGNATURE <u>James E. Andrews MD</u> PHYSICIAN'S NAME (Type) <u>James E. Andrews MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-31-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST PAULS Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>WALDORF</u> <u>777d</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home Waldorf, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 3 '58</u>	
24b. REGISTRAR'S SIGNATURE <u> </u>			

BUREAU V. S.

FEB 3 1978

RECEIVED

586

CERTIFICATE OF DEATH

00582

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bay View Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARRY J. JOHNSON</u>				4. DATE OF DEATH Month Day Year <u>JAN. 4 1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 27, 1916</u>	
9. AGE (In years last birthday) <u>41</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Joseph Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Bonnie Penn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Adrian Johnson Bryantown Dc</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malnutrition and Terminal Pneumonia</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebrovascular Hemorrhage</u> 4 1/2 mo. (c) <u>Generalized Arteriosclerosis</u> years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no injury</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>30 Aug.</u> 19 <u>57</u> , to <u>4 JAN.</u> 19 <u>58</u> , that I last saw the deceased alive on <u>4 JAN</u> 19 <u>58</u> , and that death occurred at <u>2:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Vernon B. Dettor</u> M.D. <u>La Plata, Md.</u> <u>1-6-58</u> PHYSICIAN'S NAME (Type) <u>VERNON B. DETTOR</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1/8/58</u>		<u>St. Marys</u>		<u>Bryantown Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>The Ninth Annual Home Workshop</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 9 1958

BUREAU V. A.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

NAME OF DECEASED: *John A. Smith*
AGE: *45* SEX: *M*
DATE OF DEATH: *Jan 8 1958*
PLACE OF DEATH: *Home*
CAUSE OF DEATH: *Heart Disease*
MANNER OF DEATH: *Natural*
SIGNATURE OF PHYSICIAN: *John A. Smith*
SIGNATURE OF REGISTRAR: *John A. Smith*
DATE OF REGISTRATION: *Jan 9 1958*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

587

CERTIFICATE OF DEATH

00583

Item 8, Film G224, 1/21/58

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY CHARLES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) POMONKEY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) POMONKEY	
c. LENGTH OF STAY IN 1b —		d. STREET ADDRESS RFD LA PLATA, MD.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANK Middle LITTLE Last LITTLE		4. DATE OF DEATH Month JAN Day 13 Year 1958	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 5, 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) 74 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) KY.	
13. FATHER'S NAME William Little		12. CITIZEN OF WHAT COUNTRY? USA.	
14. MOTHER'S MAIDEN NAME Mary H. Wooten		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 302 16 0116		17. INFORMANT MARY H. KNAPP Address RFD LA PLATA, MD. POMONKEY, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRAGE 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 WK	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN 6 , 19 58 , to JAN 13 , 19 58 , that I last saw the deceased alive on JAN 13 , 19 58 , and that death occurred at 10:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Frank G. Susan M.D. PHYSICIAN'S NAME (Type) DR. FRANK SUSAN Indian Head, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 1-14-1958	
22c. NAME OF CEMETERY OR CREMATORY IRONTOWN, OHIO CEM.		22d. LOCATION (City, town, or county) (State) Irontown Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE HUNT FUNERAL HOME ADDRESS WALDORE, MD.		24a. REC'D BY REGISTRAR JAN 16 '58 24b. REGISTRAR'S SIGNATURE W. H. H. H.	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH	
9. OCCUPATION		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. MEDICAL HISTORY		13. PRESENT ILLNESS		14. TREATMENT		15. POST-MORTEM		16. SIGNATURE OF PHYSICIAN	
17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF WITNESS		19. SIGNATURE OF DECEASED		20. SIGNATURE OF NEXT OF KIN		21. SIGNATURE OF CLERGYMAN		22. SIGNATURE OF BURIAL OFFICER		23. SIGNATURE OF FUNERAL HOME		24. SIGNATURE OF OTHER	

BUREAU V. S.

JAN 16 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

588 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00584

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Charles</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mason Springs</i>			c. LENGTH OF STAY IN 1b <i>4 mos.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mason Springs</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>RFD La Plata</i>				d. STREET ADDRESS <i>RFD La Plata</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <i>George</i> Middle <i>Samuel</i> Last <i>Maddox</i>				4. DATE OF DEATH Month <i>January</i> Day <i>31</i> Year <i>1958</i>				
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Negro</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>OCT 7, 1957</i>		
9. AGE (In years last birthday) yrs. <i>5</i> Months <i>3</i> Days <i>24</i> Hours <i></i> Min. <i></i>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>		11. BIRTHPLACE (State or foreign country) <i>Mason Springs, Md</i>		
13. FATHER'S NAME <i>William Thomas Maddox</i>				14. MOTHER'S MAIDEN NAME <i>Dolores Elizabeth Montgomery</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i></i>		16. SOCIAL SECURITY NO. <i></i>		17. INFORMANT Address <i></i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>500 x Tracheo-Brachitis acute Primary</i> DUE TO (b) <i></i> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) <i></i> DUE TO (c) <i></i>							INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Frank A. Susan</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>1-31-58</i>		
EXAMINER'S NAME (Type) <i>Frank A. Susan M.D.</i>				22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				
22b. DATE THEREOF <i>Feb. 3, 1958</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St. Charles</i>		22d. LOCATION (City, town, or county) (State) <i>Indian Head, Md.</i>		23. FUNERAL DIRECTOR'S SIGNATURE <i>Funeral Home, Waldorf, Md.</i>		
ADDRESS <i>Funeral Home, Waldorf, Md.</i>				24a. REC'D BY REGISTRAR DATE <i>FEB 5 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. H. Beach</i>		

4000193XV5

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1958 5 FEB

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Star Laplata Md.</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Phy. Med. Hosp.</u>		d. STREET ADDRESS <u>La Plata</u>	
3. NAME OF DECEASED (Type or print) <u>SIDLER, MAYNARD E</u>		4. DATE OF DEATH Month <u>1</u> Day <u>26</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-4-1909</u>
9. AGE (In years last birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>8</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Navy Powder factory</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Pisgah md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George W Sidler</u>		14. MOTHER'S MAIDEN NAME <u>Sarah J Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>218-03-1611</u>	
17. INFORMANT <u>Mrs. George Sidler</u>		Address <u>Laplata md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Space & Vert & Deverano of</u> 823X DUE TO <u>Spine Cord</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>Auto accident</u> (b) <u>1-23-58</u> (c) <u>1-23-58</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Car crashed into tree</u>	
20c. TIME OF INJURY Month, Day, Year <u>1-23-58</u> a. m. <u>3</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) <u>Charles</u> (County) <u>MD</u> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>R. J. Edelen</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>R. J. Edelen</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-28-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Manjanny Baptist</u>		22d. LOCATION (City, town, or county) <u>Manjanny md</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Grehart Inc</u> ADDRESS <u>Laplata md.</u>		24a. REC'D BY REGISTRAR <u>W. Beach</u> DATE <u>JAN 29 '58</u>	
		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

JAN 29 1953

BUREAU V. S.

STATE OF ARIZONA
DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF EXAMINER: [illegible]
DATE: [illegible]

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
59 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00586

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Waldorf</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bel Air</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>JAMES Lee THOMPSON</i>		4. DATE OF DEATH Month <i>1</i> Day <i>3</i> Year <i>1958</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 6, 1899</i>
9. AGE (In years and birth day) <i>58</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Levy Thompson</i>		14. MOTHER'S MAIDEN NAME <i>Mary Winder</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Bel Air, Md.</i>	
17. INFORMANT <i>Bena Thompson</i>		Address <i>Bel Air, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>CORONARY OCCLUSION</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>CORONARY HEART DISEASE</i> (c) _____		INTERVAL BETWEEN ONSET AND DEATH <i>1-2-58</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>E. J. Edele</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. J. EDELEN</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Jan. 6, 1958</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St Ignatius</i>		22d. LOCATION (City, town, or county) (State) <i>Bel Air, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Health Fun. Home, Waldorf, Md.</i>		24a. REC'D BY REGISTRAR <i>DATE JAN 7 '58</i>	
24b. REGISTRAR'S SIGNATURE <i>Overman</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00587

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Dentsville</i>		c. LENGTH OF STAY IN 1b <i>6 mos.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>SALLY</i> First <i>ANNE</i> Middle <i>WATSON</i> Last		4. DATE OF DEATH Month <i>1</i> Day <i>17</i> Year <i>1958</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-10-1878</i>
9. AGE (In years last birthday) <i>79</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Shop</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>home</i>	
11. BIRTHPLACE (State or foreign country) <i>MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Richard Adams</i>		14. MOTHER'S MAIDEN NAME <i>Jane McKey??</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Jerome Watson</i> Address <i>Newburg, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Hypertension</i> (c), stating the underlying cause lost. DUE TO (c) <i>—</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1-17-58</i> <i>7</i> <i>1</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <i>1-17-58</i> <i>4</i> Hour <i>am</i> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. J. Fedele</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. J. FEDELEN</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1-20-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St Peter's Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Waldorf Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Smith Funeral Home</i> ADDRESS <i>Waldorf, Md.</i>		24a. REC'D BY REGISTRAR <i>JAN 21 58</i> DATE	24b. REGISTRAR'S SIGNATURE <i>W. J. Smith</i>

MARYLAND STATE DEPARTMENT OF HEALTH - BIRTH-DEATH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form 100-100

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. MARITAL STATUS</p>		<p>8. CAUSE OF DEATH</p>	
<p>9. MANNER OF DEATH</p>		<p>10. SIGNATURE OF EXAMINER</p>	
<p>11. DATE OF DEATH</p>		<p>12. TIME OF DEATH</p>	
<p>13. PLACE OF DEATH</p>		<p>14. SIGNATURE OF WITNESS</p>	
<p>15. SIGNATURE OF NEXT OF KIN</p>		<p>16. SIGNATURE OF MINISTER</p>	
<p>17. SIGNATURE OF CLERGYMAN</p>		<p>18. SIGNATURE OF JUDGE</p>	
<p>19. SIGNATURE OF SHERIFF</p>		<p>20. SIGNATURE OF CORONER</p>	
<p>21. SIGNATURE OF HEALTH OFFICER</p>		<p>22. SIGNATURE OF DEATH REGISTRAR</p>	
<p>23. SIGNATURE OF BURIAL OFFICER</p>		<p>24. SIGNATURE OF INTERMENT OFFICER</p>	
<p>25. SIGNATURE OF FUNERAL HOME</p>		<p>26. SIGNATURE OF CEMETERY</p>	
<p>27. SIGNATURE OF CHURCH</p>		<p>28. SIGNATURE OF PARISH</p>	
<p>29. SIGNATURE OF DISTRICT</p>		<p>30. SIGNATURE OF COUNTY</p>	
<p>31. SIGNATURE OF STATE</p>		<p>32. SIGNATURE OF UNION</p>	
<p>33. SIGNATURE OF NATION</p>		<p>34. SIGNATURE OF WORLD</p>	
<p>35. SIGNATURE OF UNIVERSE</p>		<p>36. SIGNATURE OF GOD</p>	
<p>37. SIGNATURE OF HEAVEN</p>		<p>38. SIGNATURE OF EARTH</p>	
<p>39. SIGNATURE OF AIR</p>		<p>40. SIGNATURE OF FIRE</p>	
<p>41. SIGNATURE OF WATER</p>		<p>42. SIGNATURE OF LAND</p>	
<p>43. SIGNATURE OF MOUNTAINS</p>		<p>44. SIGNATURE OF RIVERS</p>	
<p>45. SIGNATURE OF LAKES</p>		<p>46. SIGNATURE OF OCEANS</p>	
<p>47. SIGNATURE OF ISLANDS</p>		<p>48. SIGNATURE OF CONTINENTS</p>	
<p>49. SIGNATURE OF PLANETS</p>		<p>50. SIGNATURE OF STARS</p>	
<p>51. SIGNATURE OF MOONS</p>		<p>52. SIGNATURE OF COMETS</p>	
<p>53. SIGNATURE OF METEORS</p>		<p>54. SIGNATURE OF AURORAS</p>	
<p>55. SIGNATURE OF ECLIPSES</p>		<p>56. SIGNATURE OF SOLAR FLARES</p>	
<p>57. SIGNATURE OF COSMIC RAYS</p>		<p>58. SIGNATURE OF GRAVITATIONAL WAVES</p>	
<p>59. SIGNATURE OF DARK MATTER</p>		<p>60. SIGNATURE OF DARK ENERGY</p>	
<p>61. SIGNATURE OF SUPERNOVAS</p>		<p>62. SIGNATURE OF BLACK HOLES</p>	
<p>63. SIGNATURE OF WHITE DWARFS</p>		<p>64. SIGNATURE OF RED GIANTS</p>	
<p>65. SIGNATURE OF BLUE GIANTS</p>		<p>66. SIGNATURE OF ORANGE DWARFS</p>	
<p>67. SIGNATURE OF YELLOW DWARFS</p>		<p>68. SIGNATURE OF RED DWARFS</p>	
<p>69. SIGNATURE OF BROWN DWARFS</p>		<p>70. SIGNATURE OF PULSARS</p>	
<p>71. SIGNATURE OF NEBULAE</p>		<p>72. SIGNATURE OF GALAXIES</p>	
<p>73. SIGNATURE OF CLUSTERS</p>		<p>74. SIGNATURE OF SUPERCLUSTERS</p>	
<p>75. SIGNATURE OF FILAMENTS</p>		<p>76. SIGNATURE OF Voids</p>	
<p>77. SIGNATURE OF WALLS</p>		<p>78. SIGNATURE OF SHEETS</p>	
<p>79. SIGNATURE OF BUBBLES</p>		<p>80. SIGNATURE OF FIBERS</p>	
<p>81. SIGNATURE OF STREAMS</p>		<p>82. SIGNATURE OF FILaments</p>	
<p>83. SIGNATURE OF SHEETS</p>		<p>84. SIGNATURE OF WALLS</p>	
<p>85. SIGNATURE OF BUBBLES</p>		<p>86. SIGNATURE OF FIBERS</p>	
<p>87. SIGNATURE OF STREAMS</p>		<p>88. SIGNATURE OF FILaments</p>	
<p>89. SIGNATURE OF SHEETS</p>		<p>90. SIGNATURE OF WALLS</p>	
<p>91. SIGNATURE OF BUBBLES</p>		<p>92. SIGNATURE OF FIBERS</p>	
<p>93. SIGNATURE OF STREAMS</p>		<p>94. SIGNATURE OF FILaments</p>	
<p>95. SIGNATURE OF SHEETS</p>		<p>96. SIGNATURE OF WALLS</p>	
<p>97. SIGNATURE OF BUBBLES</p>		<p>98. SIGNATURE OF FIBERS</p>	
<p>99. SIGNATURE OF STREAMS</p>		<p>100. SIGNATURE OF FILaments</p>	

BUREAU V. 5

JAN 21 1953

RECEIVED